Table Age and racial origin of children with hypernatraemic and hypertonic dehydration

Type of dehydration	Age (months)			
	0-12		13-24	
	Asian	White	Asian	White
Hypernatraemic	7	3	3	0
Hypertonic (without hypernatraemia)	4	3	1	0

and racial origin of the patients in 1980 with hypernatraemia and hypertonic dehydration are shown in the Table.

Seven of the 8 children with hypertonic dehydration had serum sodium levels greater than 145 mmol/l, a trend towards hypernatraemia. The type of milk given to the patient before admission was appropriate in every case and no particular pathogen played a major role in the disorder. These figures show that the incidence of hypernatraemia has not changed here during the last decade, and that education in the making-up of feeds and the use of appropriate oral fluids in the treatment of gastroenteritis is still needed.

Reference

- 1 Manuel P D, Walker-Smith J A. Decline of hypernatraemia as a problem in gastroenteritis. *Arch Dis Child* 1980; **55**: 124-7.

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Child health services after reorganisation

Sir,

The annotation by Dr Wilson¹ fills one with despair. So soon after the publication of the infant mortality statistics in different countries in the Court Report which showed how we have been so sadly overtaken, and at a time when our immunisation figures are so conspicuously bad, when childhood tuberculosis has recurred, family break up, smoking, violence, and accidents are all increasing, and schools are increasingly wreaking havoc on children's minds and personalities, how can you publish the sentence 'there will be little change in the child health services and no cause for concern.'?

The big advances in child health in this country occurred when it was in the hands of the people whom Dr Wilson calls 'epidemiologists' (my father was secretary of the Society of Medical Officers of Health in the 1930s, and was such a one) and with the onset of the disastrous and misnamed National Health Service, the relative rate of improvement declined. Dr Wilson is making the spurious assumption (which was also made at the onset of the National 'Health' Service) that the doctors who matter for health are those who see patients, and is perpetuating the longstanding confusion of health (prevention) and chronic

care. I think that, if a doctor sees a patient, medicine has failed, and the correct sequence of importance of these aspects of medicine should be prevention, treatment, and chronic care. The one aspect of treatment which has really important preventive implications is obstetrics and neonatology, and our achievements in these have not been satisfactory until recently.

The lumping of these three categories of medicine (and 4 others which I have outlined elsewhere) together under the so-called National Health Service makes no sense, and has been very damaging, because the health (prevention) component has been given bottom priority instead of top. The prejudices of paediatricians and of your journal have also been for treatment and care; this is acceptable for a journal with your title but there is no evidence for her view that paediatrically trained people will do better than epidemiologists in forwarding child health; certainly much more health-orientated research is needed.

The sort of administrative juggling which Dr Wilson was discussing will have very little effect, good or bad, on the present state of child health, but anyone who can say that there is no cause for concern in our child health services is the wrong person to comment on them.

Reference

- 1 Wilson J A. Child health services after reorganisation. *Arch Dis Child* 1982; **57**: 1-2.

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Dr Wilson comments:

Professor Soothill has taken the sentence 'there will be little change in the child health services and no cause for concern' out of context, from an annotation which discussed the effect on the organisation of the Child Health Services, of abolishing the post of specialist in community medicine (Child Health). There is of course, considerable cause for concern about the state of our children's health. In some districts I am also concerned about the organisation of their services for children and no doubt it would have been wiser to use the phrase 'less cause for concern'. I have no doubt that the effectiveness of the present services would be greatly improved if the clinical staff were appropriately trained.

I do not dispute that an epidemiologist may have an important role to play in ensuring healthier children but I reiterate that a doctor who has no clinical experience of child health and paediatric medicine is not equipped to organise the *clinical* child health services or to train the doctors who practise there.

Professor Soothill disputes this, stating that neither the title (see above) nor the annotation indicated the restricted context to which Dr Wilson now refers.

Editor